

33559

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 27 1943 818

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 9144

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 mos. ~~XXXXXX~~
(Specify whether
In this community 20 years
years, months or days)

3. (a) PRINT FULL NAME Salena Skates

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 10, 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 5 29 hr. _____ min.

9. Birthplace _____ (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER { 12. Name Nick Gordon
13. Birthplace _____ (City, town, or county) Miss (State or foreign country)
14. Maiden name Ocie Orphan
15. Birthplace _____ (City, town, or county) Ga. (State or foreign country)

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 18 '43
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director English and Co.

(b) Address 2931 Lusk Ave.

19. (a) OCT 18 1943 (Date received local registrar) (b) J. J. Bruders (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 402 S. 22nd
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1943 hour 5 minute 35 A. M.

21. I hereby certify that I attended the deceased from May
9, 19 43 to October 9, 19 43;
that I last saw her alive on October 9, 19 43;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Autopsy: Squamous Cell Carcinoma Unk.
(primary site undetermined)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Fleet (M. D. or other) _____
Address 2601 N. Whittier Date signed 10/15/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Burleson English

Licensed Embalmer No. *4208*

P. O. Address *2931 Lucas Ave*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.